



Michigan Partners for Parity

Partners for Parity Statement regarding House Bills 4183 4476

Michigan Partners for Parity exists for the sole purpose of fighting for insurance coverage for all brain disorders - mental illnesses, developmental disorders and substance use disorders - that equals the medical coverage within an insurance policy. We have always considered all pervasive developmental disorders, including autism spectrum disorder, to be included in mental health parity legislation. Michigan Partners for Parity supports a comprehensive approach in which clear language including all pervasive developmental disorders could be included in HB's 4597-4600. Additionally, we support moving HB's 4183 and 4476 only if HB's 4597-4600 are also allowed to be considered in the House Health Policy Committee and on the floor of the House of Representatives.

Coalition members listed on reverse



Michigan Partners for Parity

Partner Organizations

AFSCME Council 25—MI Chapter	Michigan Association of School Psychologists
Agoraphobics in Motion (AIM)	Michigan Association of School Social Workers
Alliance for Mental Health Services	Michigan Association of Substance Abuse Coordinating Agencies
Association of Behavioral Healthcare of Michigan	Michigan Association of Suicidology
Association for Children's Mental Health	Michigan CAT
Association for Licensed Substance Abuse Organizations	Michigan Counseling Association
Birmingham Maple Clinic	Michigan Disability Rights Coalition
CHADD Michigan	Michigan Federation for Children and Families
The Comfort Zone	Michigan Jewish Conference
Common Ground Sanctuary	Michigan League for Human Services
Community Connections of SW Michigan	Michigan Mental Health Consumers Forum
Consumer Advisory Council, Washtenaw Community Health Organization	Michigan Nurses Association
Council of Catholic Women, Archdiocese of Detroit	Michigan Occupational Therapy Association
Depression and Bipolar Support Alliance-Grand Rapids	Michigan Protection and Advocacy Service, Inc.
Depression and Bipolar Support Alliance-Metro Detroit	Michigan Psychiatric Society
Epilepsy Foundation of Michigan	Michigan Psychoanalytic Society
Employees Assistance Professionals Association, Greater Detroit Chapter	Michigan Psychological Association
Grand Rapids Children and Adults with Attention Deficit Disorder	Michigan Society of Addiction Medicine
International Association for Psychosocial Rehabilitation Services, Michigan Chapter	Michigan State Medical Society
Kadima	Michigan Women Psychologists
Katherine's Quality Cleaning Service	Ministry in Mental Illness, Webster Church UCC, Dexter
League of Women Voters of Michigan	National Alliance on Mental Illness--Michigan
Mental Health Association in Michigan	National Association of Social Workers—MI Chapter
Michigan Association for Children with Emotional Disorders	National Council on Alcoholism and Drug Dependence of Michigan
Michigan Association of Alcoholism and Drug Abuse Counselors	Oakland County Council for Children and Adults with Psychiatric Disabilities
Michigan Association of Community Mental Health Boards	Proaction Behavioral Healthcare Alliance
Michigan Association of Program Directors of Substance Abuse	Rose Hill Center
	R&S Foods, Inc.
	West Michigan Addiction Consultants, P.C.

MICHIGAN PSYCHOLOGICAL ASSOCIATION

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House Health Policy Committee
June 2, 2009

Testimony re HB 4476 and HB 4183

Judith A. Kovach, Ph.D.
Executive Director
Michigan Psychological Association

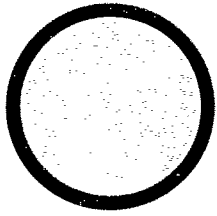
Several studies have suggested that children are the hardest-hit age group when it comes to inaccessibility of services due to lack of parity. (Busch, S.H. and C.L. Barry. "Mental Health Disorders in Childhood: Assessing the Burden on Families," *Health Affairs*, Volume 26 No 4, July - August 2007). Many of the children for whom mental health services are unavailable or inadequate are those children with autism spectrum disorders. However, these children comprise only a small percentage of all children suffering from mental and emotional disorders, pervasive developmental disabilities and other neurobiological disorders, including major depressive disorders, bipolar disorder, attention deficit disorders, Tourette's Disorder, anxiety disorders and attachment disorders. Like the autism spectrum disorders, all of these have devastating emotional and financial consequences, especially if untreated, for the children with the disorders and for their families.

For sixteen years, Michigan Partners for Parity and its affiliated organizations representing families, advocates and providers, has struggled to have comprehensive mental health parity bills passed which would cover all of the disorders and would eliminate the profoundly inequitable, fundamentally irrational and blatantly discriminatory practice of insurance companies' restricting access to mental health care, even when policies "provide" mental health coverage.

To single out autism spectrum disorders for coverage while other emotional and mental disorders are excluded continues the insurance discrimination against people/children with mental illness. Neuroscience and genetic studies more and more definitively indicate that virtually all mental and emotional disorders and pervasive developmental disorders have neurobiological antecedents. We believe we must fight for equal

exclusive and would protect all children suffering from emotional or neurobiological disorders from insurance discrimination. Furthermore, we believe that the comprehensive parity bills as written are already inclusive of the autism spectrum disorders but in discussions with the proponents of proposed autism bills, we have expressed willingness to amend the current parity language to read mental health, substance abuse **and pervasive developmental disabilities**, the specific classification under which the autism spectrum disorders fall in the diagnostic and Statistical Manual (DSM-IV). Within the medical and mental health community, the definitions in the most recent DSM of all mental and emotional (including developmental) disorders are widely and generally accepted.

The Michigan Psychological Association, as a member of Michigan Partners for Parity, deplores the fact that most health care insurance providers do not pay for the treatment of autism spectrum disorders. The autism spectrum disorders are serious pervasive developmental disorders that cause marked impairment in social interaction and communication which impacts the lives of the children with this diagnosis as well as their families. However, we can only support legislation that ends discrimination against all mental, emotional, pervasive developmental and neurobiological disorders. To select one diagnosis as “worthy” of insurance coverage perpetuates the stigma and burdens on the individuals and families coping with any of the other disorders.



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June 2, 2009

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Chairman Corriveau and Members of the House Health Policy Committee:

My name is Kathleen Gross, I am the Executive Director of the Michigan Psychiatric Society (MPS), a medical specialty society representing psychiatric physicians in Michigan since 1908.

Thank you for the opportunity to make comments regarding House Bills 4476 and 4183—legislation with the worthy purpose of ensuring insurance coverage for persons with autism spectrum disorder (ASD).

MPS has been working for the passage of comprehensive mental health parity, with the accompanying goal of providing broad mental health coverage for children, including children with autism and other developmental disabilities. We are opposed to insurance policies that exclude autism or any other valid diagnosis or chronic or disabling disorder.

You have heard the position of our coalition, Partners for Parity, with which we are in full agreement. I am going to outline some of the **policy concerns** we have with the substitute bills:

- One of the lessons we have learned in our 16-year long effort to enact mental health parity in Michigan, is that **mandates** are out of favor with the Michigan Legislature. We deliberately chose language for our parity legislation that does not mandate coverage, but rather states “if you offer...it must be on par with other medical and surgical benefits.” Members of the coalition agreed early on to give up the security of having their particular disorder named for coverage and proceed with the faith that our treatments are scientifically proven and cost effective. This is the same approach that was taken with the federal parity law, which was passed last October with the support of national business and insurance groups.
- MPS is not supportive of legislative approaches that mandate **certain treatments**, whether or not they are considered to be evidence-based. Treatment is an individualized medical decision based on the individual patient's condition. In addition, medical treatments are being continuously developed and improved, and the naming of a particular treatment in statute could conceivably suppress the availability of more effective or individualized treatment in the near future.

- In addition to our concerns regarding the **singling out of a particular disorder** for private insurance coverage we are also opposed to financial minimums or maximums—these are not in the spirit of parity. We wish to see insurance coverage that provides the right treatment, in the right amount at the right time for each beneficiary with a treatable disorder, or illness or injury.
- New language in the substitute bills propose "**Medical Necessity**" as a defined term. We strongly caution against defining this term in statute. The term "medical necessity" is used by health plans and insurers in their coverage determination process and refers to what is medically necessary *for a particular patient*. It appears unwise to use this term in such a different context. This may become a regretted unanticipated consequence. Furthermore, as defined, the term is much expanded from the American Medical Association definition (which was never proposed for statute).
- The substitute bill sets a new type of **standard for treatment**--requiring the support of two peer-reviewed medical journals. This cannot be a good precedent to set into stone by statute. This sort of standard may be used, along with other data and evidence, by insurers to evaluate a treatment or procedure for coverage that was heretofore considered experimental. I don't think the legislature is prepared to determine this standard, or to keep current with the cutting edge of effectiveness research.
- When analyzing the cost issues raised by proposed autism mandates, the federal parity law, which was enacted in October 2008 and will become effective for plans renewing after October 3, 2009 must be taken into consideration. Both the caps, or financial maximums (\$50,000 annually), and the mandated treatment, Applied Behavior Analysis, could be affected by the federal law. The federal parity law will cover only employer groups of 51 and above while ERISA plans will be exempt from the proposed autism legislation, raising concerns regarding adverse selection. I have attached a more detailed discussion of this issue.

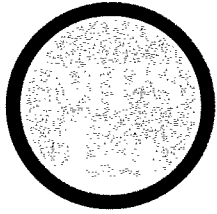
Although we cannot support an insurance mandate for a specific type of treatment for autism over other available therapies, we do believe that children and adults with autism should receive the best treatments available, including promising treatments, as that may be the best we have. This is true, not only for autism, but for other psychiatric and developmental disorders as well.

We are also concerned that the singling out of autism for mandated coverage may undermine our goal of equitable funding for ALL childhood healthcare needs by favoring one disorder over others.

If mental health parity can be achieved, we would be able to turn our efforts from combating arbitrary limits for mental health treatment to working with insurers, health plans and health systems to appropriately manage benefits and encourage the delivery of treatment that is effective.

Mental health parity offers much promise, but cannot address all the dilemmas in delivering comprehensive mental health care for all children. There will still be gaps between the private and public healthcare systems as well as the educational system. There is a need to connect and coordinate these systems. This is an area to which the legislature and the administration should direct further effort.

Again, thank you for the opportunity to address our concerns...and especially for the Committee's interest and work toward better health for children and adults in Michigan.



Michigan Psychiatric Society

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Implications of the federal mental health parity law and Michigan's proposed state autism mandate

When analyzing the cost issues raised by proposed autism mandates, the federal parity law, which was enacted in October 2008 and will become effective for plans renewing after October 3, 2009 must be taken into consideration. Both the caps, or financial maximums (\$50,000 annually), and the mandated treatment, Applied Behavior Analysis could be affected by the federal law.

To clarify, the federal law, the Mental Health and Addiction Equity Act, would not allow dollar limits or other treatment limitations ("frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment") that are "more restrictive than the predominant financial requirements/treatment limitations of substantially all medical and surgical benefits covered by the plan."

The federal law specifically allows plans to make medical necessity determinations, but they must make their criteria available. The federal law is not a mandate, but rather: "if you offer it must be on par." However, the law has a specific provision that it will not preempt existing state laws, but rather wrap around. Thus, if we enact an autism treatment mandate, plans affected by the federal law will not be able to exclude autism. If we require the delivery of Applied Behavior Analysis in state statute, it can be presumed that the federal law would prohibit the application of the types of limits that have been inserted in other state statutes (clearly the dollar maximums, perhaps the age coverage limits). Thus, the federal parity law would clearly impact the existing cost analyses.

Any actuary or cost studies that have been conducted for other states are based on that states' own analysis of the number of children with ASD (generally based on those children currently receiving services or treatment) and the proposed amendments that set limits of \$36,000 or \$50,000 annually (some states also have lifetime limits). So, these cost estimates are not accurate once the federal parity law becomes effective. Autism Speaks' own actuary stated that ABA treatment costs can exceed \$50,000 annually.

Insofar as an autism mandate would reach group plans of 50 or less or individual coverage in Michigan, the costs of ABA would quickly exceed the annual and lifetime limits imposed on most mental health benefits of these groups (not subject to federal parity law), thus leaving the individual with autism without coverage for other mental health treatments. A 2005 survey of children with pervasive developmental disorders showed that approximately half (50%) were being prescribed a psychotropic drug. New research published in 2008 showed that in a cohort of ten- to 14 year old children with ASD, 70% had at least one comorbid psychiatric disorder and 41% had two or more. The most common diagnoses were social anxiety disorder, ADHD, and opposition defiant disorder. Other studies have found a significant comorbid prevalence of ASD and bipolar disorder.

Another cost consideration that should be taken into consideration are the insurance effects of adverse selection and moral hazard. Several of Autism Speaks' model states have exempted small businesses, and it has been acknowledged that this is likely in the Michigan bills. If the legislation applies only to groups of 50 and over, there will be a response from families to seek employers in that insurance market. Considering the factor that ERISA plans, while covered by federal parity, will not be affected by this state mandate (a mandate for a particular expensive treatment that is currently not covered), the pool for this kind of coverage becomes much smaller...it can be expected that it would drive costs up due to adverse selection. The effect of moral hazard may be significant due to the protection against imposed limits for a named treatment which does not have natural limits (40 hours of ABA a week are recommended, with few limitations on duration or optimal age of the child).

--Kathleen Gross, Michigan Psychiatric Society 6/2/09

Testimony of Mark Reinstein
House Health Policy Committee – June 2, 2009

Chairman Corriveau and Members of the Committee,

I'm Mark Reinstein, a resident of Ann Arbor. I am employed by the Mental Health Association in Michigan, and some of you may know me in that role, but I am here today as a parent – the father of two individuals who began experiencing depression as minors.

My 22-year-old son has battled major depression for five years and has never been able to maintain a consistent level of recovery. My 17-year-old daughter started experiencing depression two years ago. Her recovery status is presently higher and more promising.

With your indulgence over the next moment or two, I'll pose some rhetorical questions:

Do you know what it's like to see your children hopeless and totally dysfunctional, frozen in their beds and paralyzed by fear? I do.

Do you know what it's like to realize you can't leave your child alone because of what he might do to himself? I do.

Do you know what it's like to see your child turn to illicit drugs to self-medicate dysfunctional brain chemistry? I do.

Do you know what it's like to see your child fail in important endeavors and lose all sense of self-worth? I do.

Do you know what it's like to realize your child might not make it in society, and wonder and worry about what will happen when you're gone? I do.

Do you know what it's like to have a fistfight with your son, whom you love more than anything in the world, because he explodes from emotional pain? I do.

Do you know what it's like to scramble for seven years combined to pay 50% of your children's behavioral health treatment (with no end in sight) under discriminatory insurance coverage that fully takes care of all their other health needs? I do.

I work for a small organization. The mental health parity improvement law from Congress last year does nothing for me and my family. Only a state parity law can help us. I don't wish the slightest ill will on anyone experiencing autism. And I don't claim that my experiences are more profound than those of other parents whose sons and daughters have experienced brain disorders. The answer is not to have a competition about what disorders are most meaningful. The answer is to prevent insurance discrimination against all brain disorders. The bills before you today don't do that; they single out one brain disorder at the discriminatory expense of all others. If that's going to be the case, I leave you with my final rhetorical question: What makes my children less important than those with autism?

Thank you.

